DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 10145 (01/06)

AGENCY POSITION ON THE MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) ERROR FINDING

Complete, sign and return this form with documentation to the following address.

Wisconsin Department of Health and Family Services
Division of Health Care Financing
Bureau of Eligibility Management / Attn: Medicaid Quality Assurance
P.O. Box 309
Madison, WI 53701-0309

CARES Case Number	**Case Name**

☐ **We agree with the error finding.**
If necessary, correct the case and submit documentation of your corrective action within 30 days. If an overpayment occurred due to client error, establish a claim to initiate benefit recovery. For error reduction initiatives, what information from the client, agency or state would have helped prevent this error? **Please respond within 30 days.**

☐ **We disagree with the error finding.**
Provide additional information and/or documentation to explain why you feel the eligibility determination was correct. **Please respond within 14 days.**

SIGNATURE – Agency Representative	TITLE / POSITION	Date Signed

AGENCY NAME